STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
GROUP PROVIDER ENROLLMENT FORM

Provider Number	Link ID	(Shaded Area for EDS use only)

Name Type_____
Census Tract_____
Cnty Code_____
Town Code_____
Location_____

1. Group Name _____

2. Business Name (if applicable) _____

3. Business Type ☐ Corporation ☐ LLC ☐ Partnership ☐ Franchise ☐ Other
(Attach supporting documentation)

4. Owner/Administrator, Managing Employee or Officer of Corporation Name **O**____ **A**_____

_____

5. FEIN _____

6. Service Location Address _____ City _____ State____ Zip_____

Telephone (___) _____ Fax Number _____

7. Pay to Address _____ City _____ State_____ Zip_____

8. Mail to Address _____ City _____ State_____ Zip_____

Telephone (___) _____ Fax Number _____

9. Billing Service Address _____ City _____ State_____ Zip_____

Telephone (___) _____Fax Number _____

10. Additional Practice Locations:

Street_____ City _____ State_____ Zip_____

Street_____ City _____ State_____ Zip_____

Street_____ City _____ State_____ Zip_____

11. Office Email Address _____ Contact Person_____

12. Are you currently or have you ever been a provider under another medical specialty with Medical Assistance? ☐ YES ☐ NO

Dates: (Active and Inactive) _____

Status: _____

If Yes: What is your Rhode Island Medical Assistance ID Number/s _____

13. Is this application due to a merger, buy out or take over?

☐ YES ☐ NO

14. List any outstanding balance owed to Department of Human Services Medical Assistance by previous provider? _____

15. List your Medical Specialty _____ (see attached document)

16. National Provider Identifier (NPI) Number/s_____

17. Taxonomy Number/s _____

18. EMC Biller ☐ YES ☐ NO

19. Fiscal Year End Date_____

20. Enrollment effective date or date first served RI Medical Assistance (Medicaid) client.

_____ (Effective date is mandatory)

21. Exclusions under 42 CFR and/or sections 1128B and 1932(d)(1) of the Social Security Act: Prohibits you from 1) knowingly having a director, officer, partner, or person with a beneficial ownership of more than 5 percent of the entity's equity who is debarred, suspended, excluded, or has been convicted of a criminal offence related to that person's involvement in any Federal program, or 2) having an employment, consulting, or other agreement with an individual or entity for the provision of items and services that are significant and material to the entity's obligations under its contract with the State where the individual or entity is debarred, suspended, excluded, or convicted of a criminal offence related to that person's involvement in any Federal program.

This applies to myself and/or the entity(s): ☐ YES ☐ NO

If Yes, Please List (a) Date of Issuance, (b) Duration, (c) Name and address of person**:**

_____

_____

_____

_____

22. Document information on any debarment, suspension, exclusion, or criminal offence from federal program?

_____

_____

_____

_____

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I certify that the foregoing information is true, accurate, and complete with the understanding that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws.

Signature of Provider, Senior Partner, Chief Corporate Officer, or Authorized Agent Title Date

Full Name (printed)

Nov. 2008

STATE OF RHODE ISLAND
DEPARTMENT OF HUMAN SERVICES
ADDING MEMBERS TO AN EXISTING GROUP PROVIDER APPLICATION FORM

Group Name:_____

Service Location Address: _____

_____

Pay To Address: _____

_____

Mail To Address: _____

_____

Phone Number: _____ **Fax Number**_____

Group Email Address _____

Group National Provider Identifier (NPI) Number:_____

Group Taxonomy(s):_____

Medical Assistance Group Provider Number: _____

Group's Tax Identification Number: _____

EDS use only	
Census Track:	**County Code:**
Town Code:	**Location Code:**

NEW GROUP MEMBERS:

I understand fully the standard of participation as stated in the State of Rhode Island, Department of Human Services, Provider Agreement Form (enclosed in enrollment packet) and will participate in the Rhode Island Medical Assistance Program in accordance with these standards.

PROVIDER NAME	EFFECTIVE DATE w/GROUP	NATIONAL PROVIDER IDENTIFIER	TAXONOMY(S)	LICENSE #	PROVIDER TYPE & SPECIALTY	SIGNATURE	DATE

_____

Signature of Provider, Senior Partner, or Chief Corporate Officer of Group **Title** **Date**

*****PLEASE FURNISH A COPY OF THE CURRENT LICENSE, NPI LETTER WITH TAXONOMY FOR EACH GROUP MEMBER LISTED*****

PLEASE LIST ADDITIONAL GROUP PROVIDERS ON NEXT PAGE

PLEASE LIST ADDITIONAL MEMBERS JOINING GROUP:

PROVIDER NAME	EFFECTIVE DATE w/ GROUP	NATIONAL PROVIDER IDENTIFIER	TAXONOMY(S)	LICENSE #	PROVIDER TYPE & SPECIALTY	SIGNATURE	DATE

*****PLEASE FURNISH A COPY OF THE CURRENT LICENSE, NPI LETTER WITH TAXONOMY FOR EACH GROUP MEMBER LISTED*****

PLEASE LIST ADDITIONAL GROUP PROVIDERS ON NEXT PAGE